907 KAR 1:047. Community mental health center primary care services.

RELATES TO: KRS 205.520, 205.622, 205.8451(9), 210.370-210.485, 319A.010(3), (4), 327.010(2), 334A.020(3), 369.101 – 369.120, 42 C.F.R. 400.203, 431.17, 438.2, 493, 45 C.F.R. 164, 42 U.S.C.12101 et seq., 1396r-8(a)

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6313(4)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. KRS 205.6313(4) requires the cabinet to promulgate administrative regulations to implement Medicaid reimbursement for primary care practitioners at community mental health centers. This administrative regulation establishes the Medicaid Program's coverage provisions and requirements regarding primary care services provided in a community mental health center to Medicaid recipients.

Section 1. Definitions. (1) "CLIA" means the Clinical Laboratory Improvement Amendments, 42 C.F.R. Part 493.

(2) "Community mental health center" or "CMHC" means a facility that meets the community mental health center requirements established in 902 KAR 20:091.

(3) "Department" means the Department for Medicaid Services or its designee.

(4) "Enrollee" means a recipient who is enrolled with a managed care organization.

(5) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(6) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined by 42 C.F.R. 438.2.

(7) "Medically necessary" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(8) "Occupational therapist" is defined by KRS 319A.010(3).

(9) "Occupational therapy assistant" is defined by KRS 319A.010(4).

(10) "Physical therapist" is defined by KRS 327.010(2).

(11) "Physical therapist assistant" means a skilled health care worker who:

(a) Is certified by the Kentucky Board of Physical Therapy; and

(b) Performs physical therapy and related duties as assigned by the supervising physical therapist.

(12) "Physician administered drug" or "PAD" means any rebateable covered outpatient drug that is:

(a) Provided or administered to a Medicaid recipient;

(b) Billed by a provider other than a pharmacy provider through the medical benefit, including providers who are physician offices or another outpatient clinical setting; and

(c) An injectable or non-injectable drug furnished incident to provider services that are billed separately to Medicaid.

(13) "Rebateable" means a drug for which the drug manufacturer has entered into and has in effect a rebate agreement in accordance with 42 U.S.C. 1396r-8(a).

(14) "Recipient" is defined by KRS 205.8451(9).

(15) "Speech-language pathologist" is defined by KRS 334A.020(3).

(16) "Speech-language pathology clinical fellow" means an individual who is recognized by the American Speech-Language-Hearing Association as a speech-language pathology clinical fellow.

Section 2. General Requirements. (1) For the department to reimburse for a primary care service provided by a community mental health center under this administrative regulation, the:

(a) CMHC shall be currently:

1. Enrolled in the Medicaid Program in accordance with 907 KAR 1:672;

2. Participating in the Medicaid Program in accordance with 907 KAR 1:671; and

3. Licensed in accordance with 902 KAR 20:091; and

(b) Service shall:

1. Be medically necessary;

2. Meet the coverage and related requirements established in this administrative regulation; and

3. Be provided by an individual who is currently licensed or certified in accordance with the respective Kentucky licensure or certification Kentucky Revised Statute or administrative regulation to provide the given service.

(2) In accordance with 907 KAR 17:015, Section 3(3), a CMHC that provides a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

(3) A CMHC shall:

(a) Agree to provide services in compliance with federal and state laws regardless of age, sex, race, creed, religion, national origin, handicap, or disability; and

(b) Comply with the Americans with Disabilities Act (42 U.S.C. 12101 et seq.) and any amendments to the act.

Section 3. Covered Services and PAD. (1)(a) Primary care services provided by a community mental health center and covered under this administrative regulation shall include:

1. Physician services;

2. Laboratory services if the CMHC is certified under CLIA to perform laboratory services;

3. Radiological services;

4. Occupational therapy;

5. Physical therapy; and

6. Speech-language pathology services.

(b) PAD that is administered in a CMHC shall be covered in accordance with 907 KAR 23:010.

(2)(a) The coverage of:

1. Physician services provided by a community mental health center shall be in accordance with the requirements established in 907 KAR 3:005;

2. Laboratory services provided by a community mental health center shall be in accordance with the requirements established in 907 KAR 3:005; and

3. Radiological services provided by a community mental health center shall be in accordance with the requirements established in 907 KAR 3:005.

(b) Occupational therapy provided by a community mental health center shall be covered under this administrative regulation if provided by an:

1. Occupational therapist; or

2. Occupational therapy assistant who renders services under supervision in accordance with 201 KAR 28:130.

(c) Physical therapy provided by a community mental health center shall be covered under this administrative regulation if provided by a:

1. Physical therapist; or

2. Physical therapist assistant who renders services under supervision in accordance with

201 KAR 22:053.

(d) Speech-language pathology services provided by a community mental health center shall be covered under this administrative regulation if provided by a:

1. Speech-language pathologist; or

2. Speech-language pathology clinical fellow who renders services under the supervision of a speech-language pathologist.

Section 4. Service Limitations. (1) The limitations established in 907 KAR 3:005 regarding:

(a) Physician services shall apply to physician services provided by a community mental health center;

(b) Laboratory services shall apply to laboratory services provided by a community mental health center; and

(c) Radiological services shall apply to radiological services provided by a community mental health center.

(2)(a) Except as established in paragraph (b) of this subsection, the limitations and coverage requirements established in 907 KAR 8:040 regarding occupational therapy, physical therapy, and speech-language pathology services shall apply to occupational therapy, physical therapy, and speech-language pathology services provided by a community mental health center.

(b) The provision in 907 KAR 8:040 establishing that the eligible providers of occupational therapy, physical therapy, or speech-language pathology services shall be any of the following shall not apply to a community mental health center:

1. An adult day health care program;
2. A multi-therapy agency;
3. A comprehensive outpatient rehabilitation facility;
4. A mobile health service;
5. A special health clinic; or
6. A rehabilitation agency.

Section 5. Prior Authorization Requirements. (1)(a) Except for the prior authorization requirements regarding occupational therapy, physical therapy, and speech-language pathology services and except as established in paragraph (b) of this subsection, the prior authorization requirements established in 907 KAR 3:005 for physician services, laboratory services, and radiological services shall apply to physician services, laboratory services, and radiological services provided by a CMHC under this administrative regulation.

(b) The prior authorization requirements established in 907 KAR 3:005 shall not apply to services provided to recipients who are enrolled with a managed care organization.

(2) The prior authorization requirements established in 907 KAR 8:040 regarding occupational therapy, physical therapy, and speech-language pathology services shall apply to occupational therapy, physical therapy, and speech-language pathology services provided by a community mental health center.

Section 6. Duplication of Service Prohibited. (1) The department shall not reimburse for a primary care service provided to a recipient by more than one (1) provider of any program in which primary care services are covered during the same time period.

(2) For example, if a recipient is receiving a primary care service from a rural health clinic enrolled with the Medicaid Program, the department shall not reimburse for the same primary care service provided to the same recipient during the same time period by a community mental health center.

Section 7. Records Maintenance, Protection, and Security. (1) A provider shall maintain a current health record for each recipient.

(2) A health record shall document each service provided to the recipient, including the date of the service and the signature of the individual who provided the service.

(3) The individual who provided the service shall date and sign the health record within forty-eight (48) hours of the date that the individual provided the service.

(4)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(5) A provider shall comply with 45 C.F.R. Part 164.

Section 8. Medicaid Program Participation Compliance. (1) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a provider receives any duplicate payment or overpayment from the department or a managed care organization, regardless of reason, the provider shall return the payment to the department or managed care organization in accordance with 907 KAR 1:671.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 9. Third Party Liability. A provider shall comply with KRS 205.622.

Section 10. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature.

Section 11. Auditing Authority. The department or managed care organization in which an enrollee is enrolled shall have the authority to audit any:

(1) Claim;

(2) Health record; or

(3) Documentation associated with any claim or health record.

Section 12. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 13. Appeal Rights. (1) An appeal of an adverse action by the department regarding a service and a recipient who is not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010. (43 Ky.R. 1130, 1600, 1772; eff. 5-5-2017; 44 Ky.R. 387, 1038; eff. 1-5-2018.)